

		FOR OFFICE USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0044024</u></p> <p>Facility Name: <u>SAINT CLARE HOME</u></p> <p>Address: <u>5533 N. GALENA ROAD</u> <u>PEORIA HEIGHTS</u> <u>61614</u> Number City Zip Code</p> <p>County: <u>PEORIA</u></p> <p>Telephone Number: <u>(309)682-5428</u> Fax # ()</p> <p>IDPA ID Number: <u>370813229001</u></p> <p>Date of Initial License for Current Owners: <u>09/01/98</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>CRAIG L. ATER</u> Telephone Number: <u>()</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/00</u> to <u>09/30/01</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table border="1"> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Type or Print Name) <u>Peter Bolt III</u></td> </tr> <tr> <td rowspan="5">Paid Preparer</td> <td>(Title) <u>Administrator</u></td> </tr> <tr> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>CRAIG L. ATER</u></td> </tr> <tr> <td>(Firm Name & Address) <u>Heritage Enterprises</u></td> </tr> <tr> <td>(Telephone) <u>(309)823-7135</u> Fax # () _____</td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>Peter Bolt III</u>	Paid Preparer	(Title) <u>Administrator</u>	(Signed) _____ (Date) _____	(Print Name and Title) <u>CRAIG L. ATER</u>	(Firm Name & Address) <u>Heritage Enterprises</u>	(Telephone) <u>(309)823-7135</u> Fax # () _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																
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Facility Name & ID Number SAINT CLARE HOME# 0044024 Report Period Beginning: 10/01/00 Ending: 09/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>60</u>	Skilled (SNF)	<u>60</u>	<u>21,900</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>34</u>	Intermediate (ICF)	<u>34</u>	<u>12,410</u>	3
4		Intermediate/DD			4
5	<u>4</u>	Sheltered Care (SC)	<u>4</u>	<u>1,460</u>	5
6		ICF/DD 16 or Less			6
7	<u>98</u>	TOTALS	<u>98</u>	<u>35,770</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,873</u>	<u>13,303</u>	<u>1,715</u>	<u>31,891</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	<u>875</u>	<u>532</u>	<u>0</u>	<u>1,407</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,748</u>	<u>13,835</u>	<u>1,715</u>	<u>33,298</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.09%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

none

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 09/98

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 09/98 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 1,715Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Print Preview

	G/L	RECAP CENSUS	DIFF
PP	14085	14085	0
IPA	18008	18008	0
medicare	1715	1715	0
	33808	33808	
IPA BEDHOLDS	260		
PP BEDHOLDS	250		
PP CONVERS	0		

STATE OF ILLINOIS

Page 3

Facility Name & ID Number SAINT CLARE HOME

0044024

Report Period Beginning:

10/01/00

Ending:

09/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	187,343	18,773	0	206,116		206,116	0	206,116			1
2	Food Purchase		152,849		152,849		152,849	0	152,849			2
3	Housekeeping	97,635	10,459		108,094		108,094	0	108,094			3
4	Laundry	31,459	6,821		38,280		38,280	0	38,280			4
5	Heat and Other Utilities			83,669	83,669		83,669	0	83,669			5
6	Maintenance	65,850	38,751	31,132	135,733		135,733	0	135,733			6
7	Other (specify):*							0				7
8	TOTAL General Services	382,287	227,653	114,801	724,741		724,741		724,741			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600	0	3,600			9
10	Nursing and Medical Records	1,184,337	152,490	113,669	1,450,496		1,450,496	0	1,450,496			10
10a	Therapy		99,320	184,787	284,107	(107,906)	176,201	0	176,201			10a
11	Activities	49,784	1,903	250	51,937		51,937	0	51,937			11
12	Social Services	33,128	138	875	34,141		34,141	0	34,141			12
13	Nurse Aide Training	0	0					0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16		1,267,249	253,851	303,181	1,824,281	(107,906)	1,716,375		1,716,375			16
	C. General Administration											
17	Administrative	60,000			60,000		60,000	0	60,000			17
18	Directors Fees							0				18
19	Professional Services			274,098	274,098		274,098	(4,043)	270,055			19
20	Dues, Fees, Subscriptions & Promotions			87,265	87,265	(51,465)	35,800	(6,728)	29,072			20
21	Clerical & General Office Expenses	132,854	14,654	18,942	166,450		166,450	0	166,450			21
22	Employee Benefits & Payroll Taxes			410,758	410,758		410,758	0	410,758			22
23	Inservice Training & Education			300	300		300	0	300			23
24	Travel and Seminar			3,724	3,724		3,724	(1,725)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			3,108	3,108		3,108	0	3,108			26
27	Other (specify):*			39,715	39,715		39,715	(39,715)				27
28	TOTAL General Administration	192,854	14,654	837,910	1,045,418	(51,465)	993,953	(52,211)	941,742			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,842,390	496,158	1,255,892	3,594,440	(159,371)	3,435,069	(52,211)	3,382,858			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification

Print Preview

Facility Name & ID Number SAINT CLARE HOME # 0044024 Report Period Beginning: 10/01/00 Ending: 09/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			263,361	263,361		263,361	0	263,361			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			25,344	25,344		25,344	(25,344)				32
33	Real Estate Taxes			0				0				33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			10,195	10,195		10,195	(4,756)	5,439			35
36	Other (specify):*							0				36
37	TOTAL Ownership			298,900	298,900		298,900	(30,100)	268,800			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					107,906	107,906	0	107,906			39
40	Barber and Beauty Shops	0	69	20,479	20,548		20,548	0	20,548			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					51,465	51,465	0	51,465			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		69	20,479	20,548	159,371	179,919		179,919			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,842,390	496,227	1,575,271	3,913,888	0	3,913,888	(82,311)	3,831,577			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number SAINT CLARE HOME # 0044024 STATE OF ILLINOIS Report Period Beginning: 10/01/00 Ending: 09/30/01 Page 5
VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,756)	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	(25,344)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	0	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(57)	20		17
18	Fines and Penalties				18
19	Entertainment	(1,725)	24		19
20	Contributions	(129)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(4,043)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(39,586)	27		24
25	Fund Raising, Advertising and Promotional	(6,671)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (82,311)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35) (sum of SUBTOTALS	\$		36
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (82,311)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SAINT CLARE HOME

0044024 Report Period Beginning:

10/01/00

Ending: 09/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(4,043)	0	0	0	0	0	0	0	0	0	0	(4,043)	19
20	Fees, Subscriptions & Promotions	(6,728)	0	0	0	0	0	0	0	0	0	0	(6,728)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,725)	0	0	0	0	0	0	0	0	0	0	(1,725)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(39,715)	0	0	0	0	0	0	0	0	0	0	(39,715)	27
28	TOTAL General Administration	(52,211)	0	0	0	0	0	0	0	0	0	0	(52,211)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(52,211)	0	0	0	0	0	0	0	0	0	0	(52,211)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SAINT CLARE HOME

0044024

Report Period Beginning:

10/01/00

Ending:

09/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,344)	0	0	0	0	0	0	0	0	0	0	(25,344)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(4,756)	0	0	0	0	0	0	0	0	0	0	(4,756)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(30,100)	0	0	0	0	0	0	0	0	0	0	(30,100)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(82,311)	0	0	0	0	0	0	0	0	0	0	(82,311)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

Facility Name & ID Number

SAINT CLARE HOME

#

0044024

Report Period Beginning:

10/01/00

Ending:

09/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

[Print Preview](#)

Facility Name & ID Number SAINT CLARE HOME

0044024

Report Period Beginning:

10/01/00

Ending: 09/30/01

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D

Show Pgs 8E thru 8I

Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$		\$			\$	9
	B. Non-Facility Related*												
10	Interest Income												10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$		\$			\$ 0	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
 (See instructions.)
 ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
 (See instructions.)

Print Preview

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2000 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7

Real Estate Tax History:		
Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

FOR OFF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete until this statement and the corresponding real estate tax bills are filed. If you have an

To Print this page only

Hold down
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2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME _____ COUNTY _____

FACILITY IDPH LICENSE NUMBER _____

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>0</u>	\$ <u>0</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,910 B. General Construction Type: Exterior Brick/Wood Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land		1998	\$ 224,000	1
2					2
3	TOTALS			\$ 224,000	3

Print Preview

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98				\$ 2,682,500	\$		\$	\$	\$	4
5					0						5
6	0				0						6
7											7
8											8
	Improvement Type**										
9	Smoke Detector			1999	1,932						9
10	Call Light System			1999	16,785						10
11	Sewage Ejector Pump			1999	3,800						11
12	Door Alarm System			1999	1,275						12
13	Chapel Renovation			1999	1,760						13
14											14
15	Wallpaper/Paint --Remodel Hallways			2000	45,058						15
16	Heat / Cool Pump--Rooftop A/C			2000	8,790						16
17	Corridor Renovation			2000	19,472						17
18	Cubicle Curtains			2000	4,020						18
19	Flooring -- Hallways			2000	45,048						19
20	Rooftop A/C Units			2000	328,932						20
21	Window Treatments			2000	7,221						21
22	Sign			2000	720						22
23	Chapel Renovation			2000	32,210						23
24	Smoke Detectors			2000	3,300						24
25											25
26	Wallpaper/Paint --Remodel Hallways			2001	8,820						26
27	Door Alarm			2001	12,678						27
28	Auto Door Opener			2001	1,919						28
29	Vinyl Floor Coverings -- North and West Wing Rooms			2001	73,863						29
30	Vinyl Floor Coverings -- North and West Wing Rooms --Labor			2001	3,750						30
31	Rooftop A/C Units			2001	88,341						31
32	Flooring -- Hallways			2001	3,418						32
33											33
34											34
35	Book Depreciation					206,328		206,328		528,599	35
36											36

* Total beds on this schedule must agree with page 4.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

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0 Page 12B
0 Page 12C
0 Page 12D
0 Page 12E
0 Page 12F
0 Page 12G
0 Page 12H
0 Page 12I

Facility Name & ID Number SAINT CLARE HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37								37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number SAINT CLARE HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,395,612	\$ 206,328		\$ 206,328	\$	\$ 528,599	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number SAINT CLARE HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,395,612	\$ 206,328		\$ 206,328	\$	\$ 528,599	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number SAINT CLARE HOME

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 3,395,612	\$ 206,328		\$ 206,328	\$	\$ 528,599	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

XI. OWNERSHIP COSTS (continued)
 Hold down

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar
 Control Key and hit t

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page I2D, Carried Forward		\$ 3,395,612	\$ 206,328		\$ 206,328		\$ 528,599	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
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19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

Hold down
Control Key and hit w

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page I2E, Carried Forward		\$ 3,395,612	\$ 206,328		\$ 206,328		\$ 528,599	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

Hold down
Control Key and hit k

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page I2F, Carried Forward		\$ 3,395,612	\$ 206,328		\$ 206,328		\$ 528,599	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

Hold down
Control Key and hit L

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page I2G, Carried Forward		\$ 3,395,612	\$ 206,328		\$ 206,328		\$ 528,599	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

Hold down
Control Key and hit j

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page I2H, Carried Forward		3,395,612	206,328		206,328		528,599	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 3,395,612	\$ 206,328		\$ 206,328	\$ 0	\$ 528,599	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SAINT CLARE HOME

0044024

Report Period Beginning:

10/01/00

Ending:

09/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 413,244	\$ 57,033	\$ 57,033	\$		\$ 212,185	71
72	Current Year Purchases	57,292						72
73	Fully Depreciated Assets	0						73
74								74
75	TOTALS	\$ 470,536	\$ 57,033	\$ 57,033	\$		\$ 212,185	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,090,148	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 263,361	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 263,361	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 740,784	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

[Print Preview](#)

XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 5,439 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current
rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2001 \$ _____

13. _____ /2002 \$ _____

14. _____ /2003 \$ _____

* If there is an option to buy the building,
please provide complete details on attached
schedule.** This amount plus any amortization of lease
expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number SAINT CLARE HOME

0044024

Report Period Beginning: 10/01/00

Ending: 09/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES
☐ NO

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

COMMUNITY COLLEGE

☐

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

☐

IN OTHER FACILITY

☐

HOURS PER AIDE

If "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	\$
2	Books and Supplies		0		
3	Classroom Wages (a)		0		
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your
facility received training aides from other facilities.\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for
your own aides must agree with Sch. V, line 13, col. 8.(f) Attach a schedule of the facility names and addresses
of those facilities for which you trained aides.

Print Preview

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist	10a/3	hrs	\$	
2	Licensed Speech and Language Development Therapist	10a/3	hrs			35,368			35,368	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			80,334			80,334	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescripts				99,320		99,320	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab / X-ray	39/3				8,586			8,586	13
14	TOTAL			\$		\$ 184,787	\$ 99,320		\$ 284,107	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 581,661	\$	1
2	Cash-Patient Deposits	2,970		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	702,996		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,874		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	0		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,321,501	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	224,000		13
14	Buildings, at Historical Cost	3,396,130		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	470,018		16
17	Accumulated Depreciation (book methods)	(740,784)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	0		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,349,364	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,670,865	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 282,963	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,970		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,423		30
31	Accrued Taxes Payable (excluding real estate taxes)	0		31
32	Accrued Real Estate Taxes(Sch.IX-B)	0		32
33	Accrued Interest Payable	0		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other	2,000		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 457,356	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	0		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 457,356	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,213,509	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,670,865	\$	48

*(See instructions.)

Print Preview

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,210,097	1
2	Restatements (describe):		2
3	audit Adjustment	0	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,210,097	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	3,412	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 3,412	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,213,509	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number SAINT CLARE HOME

0044024

Report Period Beginning: 10/01/00

Ending: 09/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,788,660	1
2	Discounts and Allowances for all Levels	(523,434)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,265,226	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	456,143	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 456,143	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	31,067	12
13	Barber and Beauty Care	23,283	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	0	16
17	Sale of Drugs	104,252	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	58	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 158,660	23
	D. Non-Operating Revenue		
24	Contributions	932	24
25	Interest and Other Investment Income***	36,339	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 37,271	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		0	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,917,300	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	\$ 724,741	31
32	Health Care	1,824,281	32
33	General Administration	1,045,418	33
	B. Capital Expense		
34	Ownership	298,900	34
	C. Ancillary Expense		
35	Special Cost Centers	20,548	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		0	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,913,888	40
41	Income before Income Taxes (line 30 minus line 40)**	3,412	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 3,412	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Print Preview

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,352	1,736	\$ 41,560	\$ 23.94	1
2	Assistant Director of Nursing	2,367	2,578	48,340	18.75	2
3	Registered Nurses	7,425	8,225	133,804	16.27	3
4	Licensed Practical Nurses	19,928	22,386	328,518	14.68	4
5	Nurse Aides & Orderlies	55,365	60,667	573,466	9.45	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,386	4,962	58,649	11.82	8
9	Activity Director					9
10	Activity Assistants	5,510	6,205	49,784	8.02	10
11	Social Service Workers	1,873	2,196	33,128	15.09	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	12,595	13,760	187,343	13.62	15
16	Dishwashers					16
17	Maintenance Workers	4,591	5,009	65,850	13.15	17
18	Housekeepers	10,706	11,883	97,635	8.22	18
19	Laundry	3,580	4,031	31,459	7.80	19
20	Administrator	2,080	2,080	60,000	28.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,386	9,273	132,854	14.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,144	154,991	\$ 1,842,390 *	\$ 11.89	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference
35	Dietary Consultant		\$ 0	35
36	Medical Director		3,600	36
37	Medical Records Consultant		0	37
38	Nurse Consultant			38
39	Pharmacist Consultant		550	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant		875	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)		\$ 5,025	49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference
50	Registered Nurses		\$ 9,612	50
51	Licensed Practical Nurses		14,383	51
52	Nurse Aides		83,944	52
53	TOTAL (lines 50 - 52)		\$ 107,939	53

Print Preview

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Lisa Denning		Administrator		\$ 60,000	Workers' Compensation Insurance		\$ 27,032	IDPH License Fee		\$ 0	
					Unemployment Compensation Insurance		1,165	Advertising: Employee Recruitment		12,015	
					FICA Taxes		140,943	Health Care Worker Background Check (Indicate # of checks performed _____)		674	
					Employee Health Insurance		189,805	Central Office Allocation			
					Employee Meals			Promotional Advertising		3,144	
					Illinois Municipal Retirement Fund (IMRF)*			Public Relations		3,527	
					Employee Hepatitis Vaccine		0	Dues and Subscriptions		6,771	
					Employee Benefits -		51,813	License and Fees		9,669	
					Employee Benefits - central office						
								Less: Public Relations Expense		(3,527)	
								Non-allowable advertising		(57)	
								Yellow page advertising		(3,144)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 60,000	TOTAL (agree to Schedule V, line 22, col.8)		\$ 410,758	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 29,072	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description		Line #	Amount	Description		Amount	
			\$				\$	Out-of-State Travel		\$	
								In-State Travel			
										2,018	
										157	
								Seminar Expense		1,549	
								Non Allowable		(1,725)	
								Central Office Allocation			
								Entertainment Expense		()	
								(agree to Sch. V, line 24, col. 8)			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL			\$	TOTAL		\$ 1,999	
C. Professional Services											
Vendor/Payee		Type	Amount								
Heritage Enterprises		Management Fees	\$ 236,401								
OSF Healthcare		Management Fees	20,664								
OSF Healthcare		Pastoral Services	3,808								
Advantage Behavioral		EAP Services	141								
Morehead Assoc		Employee Survey	2,988								
SMS Inc.		Medicare Consulting	3,053								
KPMG		Audit	3,000								
Hartweg, Muller		Legal	4,043								
			0								
			0								
			0								
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 274,098								

* Attach copy of IMRF notifications

**See instructions.

Print Preview

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Print Preview

Facility Name & ID Number SAINT CLARE HOME

0044024

Report Period Beginning:

10/01/00

Ending:

09/30/01

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO xx If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 51,465
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 0 Has any meal income been offset against related costs? yes Indicate the amount. \$ 3,495
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. Not complete as of the filing date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

